BOARD OF HEALTH
TOWN OF FOXBOROUGH
MASSACHUSETTS 02035
www.foxboroughma.gov

40 SOUTH STREET
Tel. (508) 543-1207
Fax. (508) 543- 6278

BHP-_____ MAKE CHECKS PAYABLE: TOWN OF FOXBOROUGH
DATE REC'D_____
CHECK#_____ *NO REFUNDS OR TRANSFER OF FUNDS*

FOOD ESTABLISHMENT PERMIT APPLICATION

(Application must be submitted at least 30 days before the planned opening/renewal date
☐ If not, Include a $200.00 Late Fee)

1. Establishment Name:	
2. Establishment Address:	
3. Establishment Mailing Address (if different):	
4. Establishment Telephone No:	4a. **E-MAIL:**
5. Applicant Name & Title:	
6. Applicant Address:	
7. Applicant Telephone No:	24 Hour Emergency No:
8. **Owner Name** & Title (if different from applicant):	
9. Owner Address (if different from applicant):	
10. Establishment Owned By: ☐ An Association ☐ A corporation ☐ An individual ☐ A partnership ☐ Other legal entity_____	11.) If a corporation or partnership, give name, title, and home address of officers or partner. Name Title Home Address _____ _____
12.) Person Directly Responsible For Daily Operations (Owner, Person in Charge, Mgr., etc.):	
NAME & TITLE:	
ADDRESS:	
TELEPHONE NO:	FAX:
EMERGENCY TELEPHONE NO:	
13.) Pest Control Co.:	14.) Sewage Disposal Private or Public
Address:	Water Source Private or Public
Phone No:	
15.) # of Food Employees:	
16.) Days of Operation:	
17.) Hours of Operation	
18.) ***Name of Person In Charge-Certified in Food Protection Management:**	
Expiration Date of Certification:	
19.) **Name of Person Trained in Anti-Choking Procedures** (If 25 Seats or More):	
Name:	**Number of Seats:**

20.) **Name of Person Certified in Allergy Awareness:**

21.) Establishment Type:	22) (Check All That Apply)	
❑ Food Service	❑ Caterer	❑ Residential Kitchen
❑ Food Service Institution	❑ Food Delivery	❑ Sale of Milk and Cream
❑ Retail/Limited	❑ Frozen Dessert Manufacturer	❑ Concession Stand
		❑ Bakery

PERMIT FEES: PAYMENT IS DUE WITH APPLICATION.
(Please make check payable to the TOWN OF FOXBOROUGH.)

FOR: Mobile Applications and Temporary Food Applications please see our website: www.foxboroughma.gov

Food Service (Restaurant)	
(1 – 100 seats)	☐ $ 50.00
(101 – 200 seats)	☐ $ 250.00
(201 – 500 seats)	☐ $ 500.00
(501 – 1,000 seats)	☐ $ 800.00
(1001+ seats)	☐ $1,000.00
Bakery	☐ $ 100.00
Catering	☐ $ 100.00
Concession Stand	☐ $ 350.00
Frozen Dessert	☐ $ 50.00
Limited Food, Limited Retail and Retail Food	☐ $ 50.00
Residential Kitchen	☐ $ 50.00
Supermarket	☐ $ 800.00
FOG PERMIT	☐ $50.00/_____
LATE FEE	☐ $ 200.00

23.) **Fats, Oils, and Grease (FOG) Management $50.00** (if more than 3, $200.00)

Please list the number of grease interceptors servicing your establishment.	Do you have yellow grease (used fry oil) disposal container/s Yes No Size/s:
Please provide information on the contractor who services these grease interceptors: Company Name: Address: Phone Number:	Please provide information on the contractor who services the yellow grease container/s: Company Name: Address: Phone Number:

☐ List staff/owners with Foxborough **FOG Certification Training:**

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable law. I have been instructed by the Board of Health on how to obtain copies of 105 CMR 590.000 and the Federal Food Code. **BOTH COPIES MUST BE KEPT ON SITE AT ALL TIMES.**

Pursuant to MGL Ch. 62C, sec. 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid state taxes required by law.

24.) **Social Security Number or Federal ID Number**_____

25.) **Signature of Individual or Corporate Name**_____ **Date**_____

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Please Print Legibly

Applicant Information

Business/Organization Name:_____

Address:_____

City/State/Zip:_____ Phone #:_____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name:_____

Insurer's Address:_____

City/State/Zip: _____

Policy # or Self-ins. Lic. #_____ Expiration Date:_____

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature:_____ Date:_____

Phone #:_____

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ **Permit/License #**_____

Issuing Authority (circle one):
1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
6. Other _____

Contact Person:_____ **Phone #:**_____

Information and Instructions

Massachusetts General Laws chapter 152 requires all employers to provide workers' compensation for their employees. Pursuant to this statute, an ***employee*** is defined as "...every person in the service of another under any contract of hire, express or implied, oral or written."

An ***employer*** is defined as "an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association or other legal entity, employing employees. However, the owner of a dwelling house having not more than three apartments and who resides therein, or the occupant of the dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or building appurtenant thereto shall not because of such employment be deemed to be an employer."

MGL chapter 152, §25C(6) also states that **"every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business or to construct buildings in the commonwealth for any applicant who has not produced acceptable evidence of compliance with the insurance coverage required."** Additionally, MGL chapter 152, §25C(7) states "Neither the commonwealth nor any of its political subdivisions shall enter into any contract for the performance of public work until acceptable evidence of compliance with the insurance requirements of this chapter have been presented to the contracting authority."

Applicants

Please fill out the workers' compensation affidavit completely, by checking the boxes that apply to your situation and, if necessary, supply your insurance company's name, address and phone number along with a certificate of insurance. Limited Liability Companies (LLC) or Limited Liability Partnerships (LLP) with no employees other than the members or partners, are not required to carry workers' compensation insurance. If an LLC or LLP does have employees, a policy is required. Be advised that this affidavit may be submitted to the Department of Industrial Accidents for confirmation of insurance coverage. **Also be sure to sign and date the affidavit.** The affidavit should be returned to the city or town that the application for the permit or license is being requested, **not** the Department of Industrial Accidents. Should you have any questions regarding the law or if you are required to obtain a workers' compensation policy, please call the Department at the number listed below. Self-insured companies should enter their self-insurance license number on the appropriate line.

City or Town Officials

Please be sure that the affidavit is complete and printed legibly. The Department has provided a space at the bottom of the affidavit for you to fill out in the event the Office of Investigations has to contact you regarding the applicant. Please be sure to fill in the permit/license number which will be used as a reference number. In addition, an applicant that must submit multiple permit/license applications in any given year, need only submit one affidavit indicating current policy information (if necessary). A copy of the affidavit that has been officially stamped or marked by the city or town may be provided to the applicant as proof that a valid affidavit is on file for future permits or licenses. A new affidavit must be filled out each year. Where a home owner or citizen is obtaining a license or permit not related to any business or commercial venture (i.e. a dog license or permit to burn leaves etc.) said person is NOT required to complete this affidavit.

The Office of Investigations would like to thank you in advance for your cooperation and should you have any questions, please do not hesitate to give us a call.

The Department's address, telephone and fax number:

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017
Tel. # 617-727-4900 ext 7406 or 1-877-MASSAFE
Fax # 617-727-7749
www.mass.gov/dia